GEORGIA DEPARTMENT OF COMMUNITY HEALTH

TOPICAL ANTIFUNGALS PA SUMMARY

PREFERRED	Ciclopirox (cream, suspension), Ketoconazole (cream, shampoo), Loprox gel, Miconazole, Nystatin cream
NON-PREFERRED	Ciclodan Kit, Ciclopirox (gel, shampoo), Econazole cream, Ertaczo (PA not required), Exelderm (PA not required), Extina foam (ketoconazole 2%), Ketoconazole 2% foam, Ketodan Kit, Loprox shampoo, LUZU, Mentax (PA not required), Naftin, Oxistat (PA not required), Pediaderm AF Kit (covered only for members less than 21 years of age), Vusion

LENGTH OF AUTHORIZATION: Varies

NOTE: If Ketoconazole foam is approved, the PA will be issued for the brand-name product, Extina. If ciclopirox shampoo is approved, the PA will be issued for the brand-name product, Loprox shampoo. PA criteria for ciclopirox solution (Ciclodan, CNL8, Penlac) is located in the "Oral Antifungals and Ciclopirox Soln" document.

PA CRITERIA:

For Ciclodan Kit

- Submit a written letter of medical necessity stating the reason(s) that generic ciclopirox cream 0.77% (preferred medication) is not appropriate for the member.

For Ciclopirox Gel

- Submit a written letter of medical necessity stating the reason(s) that brand-name Loprox gel 0.77% (preferred medication) is not appropriate for the member.

For Econazole or Naftin

- Member must have experienced trial and failure of at least one OTC or prescription topical antifungal agent that does not require prior authorization.

For Ketoconazole Foam or Ketodan Kit

- Approvable for members age 12 or older with a diagnosis of seborrheic dermatitis

AND

- Provider should submit a written letter of medical necessity stating the reason(s) the preferred product, generic ketoconazole cream or shampoo, is not appropriate for the member.

For Loprox (Ciclopirox) Shampoo

- Approvable for the diagnosis of seborrheic dermatitis

AND

- Member must have experienced ineffectiveness, allergies, contraindications, drug-drug interactions, or a history of intolerable side effects to generic ketoconazole shampoo.

For LUZU

- Approvable for members age 18 or older with a diagnosis of tinea corporis, tinea cruris, or tinea pedis confirmed by KOH (potassium hydroxide preparation) or cell culture test

AND

- Member must have tried and failed at least one OTC or prescription topical antifungal agent.

For Vusion

- Approvable for members age 4 weeks or older with a diagnosis of diaper dermatitis when the presence of a candidal infection has been confirmed by a microscopic evaluation

AND

- Member must have experienced trial and failure of a topical antifungal agent (OTC or prescription) within the past 60 days.

EXCEPTIONS:

- Exceptions to these conditions of coverage are considered through the prior authorization process.
- The Prior Authorization process may be initiated by calling **Catamaran at 1-866-525-5827.**

PA and APPEAL PROCESS:

- For online access to the PA process please go to www.mmis.georgia.gov/portal, highlight the pharmacy link on the top right side of the page, and click on "prior approval process".

QUANTITY LEVEL LIMITATIONS:

- For online access to the current Quantity Level Limit please go to www.mmis.georgia.gov/portal, highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services Part II and select that manual.